Entered into IRIS ☐

2018-2019

Daniel Pharmacy-Informed Consent to Receive Vaccines for Adults

RX #_____

RX #_____

Name:_____ Date of Birth:_____Male/Female

Mother's Maiden Name (First and Last-used for immunization registry purposes):_____

Street:_____ Physician:_____

City:_____ Zip Code:_____ Physician Phone: (_____)_____

Phone: (_____)_____ Physician Address:_____

☐Medicare ☐ Private Insurance ☐ Cash $ Amount:_____ ID #:_____

Please answer yes or no to the following questions. If any questions are unclear, please ask for assistance.	**YES**	**NO**
1. Are you sick today?		
2. Do you have allergies to medications, food, any vaccine, or latex?		
3. Have you ever had a serious reaction after receiving a vaccination?		
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (i.e. diabetes), anemia, or other blood disorder?		
5. Do you have cancer, leukemia, AIDS, or any other immune system problem? Have you had a mastectomy?		
6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments?		
7. Have you had a seizure, brain, or other nervous system problem?		
8. During the past year, have you received a transfusion of blood or blood products, been given a medicine called immune (gamma) globulin, or an antiviral drug?		
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?		
10. Have you received any vaccinations in the past 4 weeks?		

I have read, or have had read to me, the Vaccine Information Statement (VIS) indicated below. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of vaccine(s) requested. I authorize this information to be forwarded to my primary care physician, authorizing physician or local Dept. of Health if applicable. I agree to stay in the general area for 15 minutes after receiving my vaccination in case any immediate reactions occur. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I hereby release Daniel Pharmacy, its employees and agents; from any and all liability that might arise from this vaccination on behalf of myself, my heirs and personal representatives.

Patient Signature:_____ **Date:**_____

Please initial that you have received our Notice of Privacy Practice for HIPAA_____(initials)

Vaccine	Lot #	Exp. Date	Manufacturer	Dose (mL)

☐Left arm ☐Right arm ☐Nasal ☐IM ☐SC Admin. Date_____VIS Date_____

Vaccine	Lot #	Exp. Date	Manufacturer	Dose (mL)

☐Left arm ☐Right arm ☐Nasal ☐IM ☐SC Admin. Date_____VIS Date_____

Administrator_____ Daniel Pharmacy, 1114 Central Ave. Fort Dodge, IA 50501

IRIS reviewed _____(Initials) | Flu_____Pneumonia 13_____ Pneumonia 23_____Tdap_____Shingles____